

Commentary – Evaluating market reforms in the English NHS

The evidence available to evaluate and assess the impact of market reforms in the English NHS address is far from unequivocal – it is hotly contested.

The only certainty is that the NHS comprises multiple messy, complex settings and contexts that are ever-changing and shifting. Attributing causation is highly problematic which makes conducting meaningful research in such an environment challenging.

As a guide to future policy, research has weaknesses. At best it can provide useful pointers and insights although even some of these are often contradictory or full of paradoxes. Research cannot provide definitive answers despite the claims of some of its authors. Research-informed policy is therefore probably the best we can hope for.

Given the progressive marketisation of public policy, pretty much uninterrupted since the 1990s, research has focused on choice and competition as the key drivers for improvement and efficiency. Other factors that may be as, or more, important haven't been highlighted or subjected to the same degree of inquiry – management skills (eg see recent study by McKinsey's which put management ability ahead of competition and other factors as the key driver for improved services), culture (eg putting clinicians at the heart of QI), regulation, new resources.

Even the work on choice and competition sometimes fails to adopt a more nuanced approach that might reflect the complexities of the issues involved. I put this down to much of the work being pursued by economists, many of whom tend to adopt a rational, linear paradigm of how things should work. In practice, of course, they rarely do as many of the other behavioural social sciences can amply show – eg insights from political science, anthropology.

Take the issue of choice, for example. The report by the 2020 Public Services Trust at the RSA, prepared by Ipsos MORI, on what people want, need and expect from public service suggests that the issue of choice is far more complex than much of the research reported hitherto allows.

People favour choice because of the personal benefit it may provide them and their families. But when the issue is debated in greater depth, a number of potential problems arise. There is concern about the potential impacts on local areas such as the risk of good hospitals becoming oversubscribed.

There is also a public service ethos evident – individually consumed benefits from services need to be set alongside a notion of common benefit and public good.

Choice and personalisation are viewed as 'nice to have' rather than essential. Choice ranks less highly than other concerns such as the quality of care, explanations from staff and the

appearance of the ward environment. They are secondary priorities although you'd never think that from the way politicians of all parties talk.

The same survey also shows that people remain sceptical about the role that the private sector might play in delivering public services. Issues regarded as being of importance to policy-makers and some academics do not resonate with the public. The overall implication from the RSA survey is that people want public services delivered by the public sector but to private sector standards.

In sum, people take the view that 'things are private, people are public'. This is a more subtle and rather different message from the one emanating from policy-makers, their advisers and civil servants who are fixated on choice and competition as being the only options on offer. More research into such issues would seem desirable but there is a vacuum at present possibly because such research is not regarded as being in keeping with the ideological bias towards greater pluralism and diversity of provision. And most research is funded by government – or rather the public. There's a nice irony there.

One area where the evidence is pretty incontrovertible is that pointing to the limits to, and dysfunctional aspects of, 'big bang' structural reform. As Klein wrote back in 1991, although health care reform 'has been one of the worldwide epidemics of the 1990s...Britain stands out from the rest'. It still does. If the evidence shows anything it is that such upheavals are costly, rarely achieve their objectives, and often leave the problems they seek to address unresolved. Why successive governments choose to ignore what is now a sizeable body of evidence testifying to the failure of large-scale structural change is puzzling. If the issues are cultural, then they are not amenable to structural solutions.

A dilemma for researchers is the constant policy and organisational churn in the NHS which makes it well-nigh impossible to say anything lasting or clear-cut. Interestingly, the only part of the NHS landscape that has not been subjected to constant reform (until now that is) is NICE. Set up in 1999, it did undergo one significant change in 2005 when it became responsible for the HDA and its public health programme although the NICE ethos and way of doing business prevailed.

NICE is widely held up to be a respected and successful organisation both in the UK and internationally. It is probably no coincidence that it has had the same Chair and CEO since its formation. It has also escaped being subjected to every Ministerial whim and fancy and has been allowed to develop its modus operandi reasonably unhindered. As a consequence, such continuity and the absence of constant interference have allowed it to be well led and managed. Perhaps if the secret of NICE's success could be replicated more widely it would suggest rather different, and alternative, drivers for success that are not reliant on beliefs about the superiority of choice and competition as drivers for change.

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